HIPAA Information Meeting

Interest Form

Contingent upon sufficient provider interest, the AHCCCS Administration will conduct informational meetings to discuss the impact of the Health Insurance Portability and Accountability Act (HIPAA). If you are interested in attending one of these informational meetings, please return this interest form. You will be notified of the date, time, and place of the meeting. Please return this form to:

AHCCCS Policy/Training Section
Mail Drop 8100
701 E. Jefferson Street
Phoenix, AZ 85034

You also may fax this form to:

AHCCCS Policy/Training Section
(602) 256-1474

Provider Name: _____

Name of contact person: _____ Provider ID: _____

Address: _____

City: _____ State: _____ ZIP Code: _____

Telephone: ( ) _____ E-mail: _____

I would prefer to attend a meeting in (please indicate 1st, 2nd, and 3rd choice):

_____ Phoenix _____ Tucson _____ Flagstaff

Number of people who would attend meeting: _____

Please rate your knowledge of HIPAA by circling the appropriate number:

1	2	3	4	5	6	7	8	9	10
Little or no knowledge									Very knowledgeable

I am most concerned about (Check all that apply):

- ☐ Standardizing the interchange of electronic data
- ☐ Security and privacy issues
- ☐ Elimination of local codes and modifiers
- ☐ Elimination of "J" codes from HCPCS codes
- ☐ Use of a national provider identification number (NPI)
- ☐ Other (Please indicate on back)